DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8293

Registration District No. 821 — Primary Registration District No. 4553 — Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

50M-5-17-39
Rev. 5-17-39

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston Missouri (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott

(c) City or town Sikeston 0 (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Sarah Pace 200

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife ? Pace

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct (Month) 20 (Day) 62 (Year)

8. AGE: Years 77 | Months 3 | Days 3 | If less than one day hr. min.

9. Birthplace Dover Tenn (City, town, or county) Tenn (State or foreign country)

10. Usual occupation Housewife

11. Industry or business /

MOTHER FATHER

12. Name Dunlap

13. Birthplace Unknown (City, town, or county) Tenn (State or foreign country)

14. Maiden name Unknown

15. Birthplace (City, town, or county) Tenn (State or foreign country)

16. (a) Informant's own signature [signature]

(b) Address 323 S Kingshighway

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 1/25/40 (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston Mo

18. (a) Signature of funeral director Hunt-Allison

(b) Address Sikeston Mo.

19. (a) 2-7-40 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 23d year 1940 hour 11 minute 20 M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 340 – 6
District File Number
Date Filed 2/26/44

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Hunter Albritton

Licensed Embalmer No. 2940

P. O. Address Bilkerton Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

S. No. 2B
M 2-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8293

Registration District No. 82-1 Primary Registration District No. 45-53 Registrar's No.

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Sikeston (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Sarah Pace
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 77 | Months 3 | Days 3 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 4-15-1940 (Date received local registrar) (b) Guy H Presnell (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 23
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremia	
Due to diabetes, mellitus	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

54

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work (Specify type of place) (e) Means of injury

23. Signature Guy H Presnell (M. D. or other)
Address Date signed